TRAUMA MATTERS

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A Collaborative Approach Toward Assisting People in the Criminal Justice System Coping with Trauma and Mental Illness

This article is the second in a series examining trauma and trauma-related experiences among incarcerated individuals. This population is sometimes overlooked when it comes to assessing and treating trauma either upon initial contact with the prison system or post-release. This series primarily focuses on trauma in men within the prison system. Nationwide men comprise 91.3% of incarcerated individuals.

"A Collaborative Approach Toward Assisting People in the Criminal Justice System Coping with Trauma and Mental Illness" describes efforts in Connecticut by the Department of Corrections and the Department of Mental Health and Addiction Services as a means of not only assisting identified individuals but also reducing recidivism and increasing public safety.

I would like to briefly describe a recent evolution of Connecticut's service system to bring a trauma-informed perspective to services for adults involved in the criminal justice system. This evolution has been precipitated, in part, by a larger development in the state's criminal justice system which has mirrored the nation's system.

Nationally, the number of people incarcerated in jails and prisons began dramatically increasing several decades ago as states passed "get tough" sentencing laws. Connecticut followed this trend as the CT Department of Correction (DOC) census (jail plus prison) increased from 4,147 in 1980 to nearly 20,000 in the early 2000s. This increase in incarceration did not produce the expected decline in crime rate. However, the last decade has seen a recognition by criminal justice professionals, policy makers, and elected officials nationwide that this trend needs to be reversed. In addition to recognizing the toll on individual lives, families, and neighborhoods, the financial cost is severely straining the nation's county and state budgets.

I am pleased to report that Connecticut has been recognized as one of the nation's leading states in developing a smarter approach to crime. This effort has been initiated by the leadership of the state's executive, judicial, and legislative branches, and the details have been developed by a collaboration of all relevant state offices in the Criminal Justice Policy Advisory Commission (CJPAC) http://www.ct.gov/opm/cwp/view.asp?a=2970&Q=383604. The state has committed to a policy that places maximum control on the most dangerous offenders, reduces the financial burden of incarceration, reinvests the savings in effective services to offenders so they are less likely to recidivate, and actually increases public safety.

State leaders are now well aware that a majority of justice-involved individuals have trauma histories, that many need behavioral health clinical services and supports, and that a connection with treatment and support services is necessary to improve quality of life and to reduce the frequency and severity of recidivism. For more than two decades, the Department of Mental Health and Addiction Services (DMHAS) has been developing specialized programs and processes that serve persons with behavioral health needs who are involved with the criminal justice system.

The current menu of DMHAS programs includes services to adults with mental illness and/or addictions who have contact with police, criminal court, the DOC, and probation and parole officers http://www.ct.gov/dmhas/cwp/view.asp?a=2900&q=334746. The staff of these programs are knowledgeable about the effects of prior trauma and also the ways in which criminal justice system involvement and incarceration can result in further trauma. For example, services to people in this population require enhanced efforts at engagement and retention in services. One reason is that trauma may result in thinking and behaviors that can inadvertently sabotage a person's recovery efforts.

Two DMHAS programs specifically address the needs of sentenced inmates who are transitioning back to their communities. The Transitional Case Management (TCM) program serves sentenced men with addictions who are returning to Hartford, Waterbury, Norwich/New London, and New Britain/Bristol. Prior to discharge from prison, TCM staff enter the prisons to meet with TCM clients to arrange treatment services, housing, insurance, etc. upon release. After release, program staff provide outpatient substance abuse treatment and community support, and they can provide sober house rent for a limited time. The Connecticut Offender Reentry Program (CORP) serves sentenced men and women with serious mental illnesses who are returning to multiple locations in the state. Up to 18 months prior to release, CORP staff begin meeting with clients in prison for discharge planning and for twice weekly independent living skills groups. Following release, staff continue to provide assistance and connect clients with clinical and other services. CORP also provides staffed transitional housing beds as needed.

Several of the agencies with a TCM or CORP program have developed trauma-informed and gender-responsive capabilities through the Trauma and Gender Practice Improvement Collaborative, an initiative of DMHAS and the Connecticut Women's Consortium (CWC). TCM and CORP staff have participated in these trainings. DMHAS also funds Women's Jail Diversion programs in New Haven and in New Britain/Bristol with staff who have been trained on multiple trauma treatment models. These two programs provide comprehensive services, including treatment for trauma. The Advanced Supervision and Intervention Support Team (ASIST) program, operating in nine locations, is collaboratively funded and managed by DMHAS, the Judicial Branch, and DOC. ASIST uses START NOW, a trauma-informed skills program developed by the University of Connecticut Health Center for justice-involved adults.

As the state moves forward with connecting justice-involved adults with services, DMHAS and DMHAS-funded agencies will continue to provide formal and informal training to police, judges, criminal court staff, correctional officers, probation officers, and parole officers on mental illness, trauma, addictions, gender-specific issues, and interacting with adults with these issues. For example, the DOC and the Judicial Branch have established specialized Mental Health Parole and Probation units, respectively, with training from DMHAS, and these units actively work with service providers to support success in the community for shared clients with serious mental illness. In addition, since 2007, through an intimate partner violence grant from the State of CT Department of Public Health, the CT Women's Consortium has run five-session Healing Trauma groups, a model authored by Stephanie S. Covington, PhD with Eileen M. Russo, MA, LADC, at York Correctional Institution, the women's prison in Niantic, CT.

These improvements by Connecticut's service providers and the criminal justice system have demonstrated multiple benefits for justice-involved adults and other citizens—improved public safety, more effective and efficient use of state funds, and better quality of life for the individuals served. We are fortunate to live in a state that has implemented and is expanding these initiatives, and I want to assure all individuals who have contributed to this effort that their work is making a measurable difference and state leaders recognize this.

Submitted by Loel Meckel, LCSW, Assistant Director, Division of Forensics, CT DMHAS

Peer Support and Trauma

I became a Peer Specialist in 2001. After my training and certification, I was hired as project manager for the Georgia Certified Peer Specialist program. Fresh off of Social Security Disability and part-time employment, I was suddenly thrust into the world of deadlines, expectations, and accountability. I could not have been happier. My experience as a psychiatric patient was no longer a source of shame and humiliation, but now a source of strength and insight in guiding new practices grounded in the understanding that recovery can and does happen.

I had never quite accepted the idea that I was ill—despite the hospitalizations and the medications. Very early on, I had been told, like so many others that what had happened to me was secondary to what was wrong with me. As I began to train other peer specialists and do presentations, I found that I was re-telling my own story through the lens

of illness and coping with illness. We did not talk about trauma. In fact, it was very common in the past and in some places still is, for peer specialists to be told that trauma is off limits when it comes to peer support.

The unintended consequence was that I, along with other peer specialists, talked about the power of peer support to aid in recovery—except when it comes to trauma. The absence of trauma in our stories of recovery seemed to imply that trauma and adverse life events are rare. This lack of acknowledgment can also be felt as an extension of the silence that accompanies violence and abuse. I had no language then to talk about what had happened to me. The good news is that there is a shift towards trauma language inclusion in some peer models. At *Advocacy Unlimited Recovery University* in Connecticut, peers receive specific training on trauma and trauma-informed care.

Trauma in the context of peer support generates discomfort for some, despite work begun in the 1990s with the SAMHSA convened conference, Dare to Vision, and the Women, Co-Occurring Disorders and Violence Study. With these initiatives, the understanding of the prevalence and effect of trauma has been a driving force in developing trauma-informed cultures. And, since 2004, the involvement of people with lived experience has been one of the six core strategies for the reduction of seclusion and restraint. (Jennings, 2008).

Peer support brings with it a nonclinical focus that grounds us in the understanding that we are all affected by the world in which we live. Much of what has been classified as illness is a normal reaction to abnormal events. Clinical language naturally gives way to the language of human experience, because it is how people communicate what has happened in their lives. When peer supporters share their experiences what it often reveals is the ways that established methods, even in recovery-based treatment environments, can create barriers to recovery. For example, people are not only dealing with the distress that brings them into a hospital, but also with the loss of choice and control over what is happening to them when a unit door locks behind them.

Trauma-informed cultures of care are based on five core principles: safety, choice, trust, collaboration, and empowerment (Fallot & Harris, 2001). In peer support, these principles are enacted through relationships that are attuned to the issues of power and powerlessness and the need for both emotional and physical safety. Experiencing safety is relational; trust occurs in the context of shared vulnerability or story. Collaboration is grounded in an understanding of our mutual effect on each other—that is, that both people's needs matter (Mead, 2003). Empowerment is the action of a community creating social and system change. Trauma-informed peer support reconnects people to the contexts in which they live, as well as challenging the beliefs and assumptions that were internalized as a result of the psychiatric experience.

Recovery is often less about coping with disability and more about recontextualizing life as part of healing from the impact of adverse life events. It is about developing new meaning and new insight as a result of what has been lived. It is about reconnecting to community, often through social action. All of this takes place through the action of relationships that can be enhanced through an integrated agency peer support model.

Submitted by Beth Filson, CPS, MFA

For a complete list of references for this article please visit: www.womensconsortium.org/references_Trauma_Matters.cfm. *Beth Filson will be speaking on peer support models at the CT Women's Consortium on April 14th, May 1st and May 2nd. For more information go to: www.womensconsortium.org*

Of Note

A key part of the Connecticut Trauma Initiative is the Trauma and Gender Practice Improvement Collaborative which includes Department of Mental Health and Addiction Services (DMHAS)-operated and funded mental-health and addiction services agencies that go through a 2-year consultant-guided change process to more fully implement trauma-informed and gender-responsive services. Each year DMHAS and the CT Women's Consortium release a request for qualifications (RFQ) to select agencies to participate.

This year, two agencies are completing their 2-year process: Recovery Network of Programs (RNP) and Wheeler Clinic. This process is about fostering culture change, which may take from 3 to 5 years. The hope is that the 2-year consultant-guided process will build an infrastructure, so changes can continue to take place well beyond the first 2 years.

Four agencies are currently at the mid-point of their change process: Community Health Resources (CHR), InterCommunity, Reliance House, and River Valley Services (RVS). They recently participated in a day-long review and report of their progress.

Four agencies were recently selected from a competitive pool of RFQ applicants and took part in a 2-day kick-off event to begin their process: Columbus House, Connecticut Mental Health Center (CMHC), Connecticut Valley Hospital (CVH)-General Psychiatry Division, and Mental Health Association of CT.

Congratulations and thanks to all these agencies for their commitment to being part of this process and their hard work to achieve important changes for their organizations and services. We expect to release another RFQ in the winter of 2014.

Submitted by Julienne Giard, MSW

Ask the Experts:
A Conversation with Lori Beyer, LICSW, MSWAC

Lori Beyer, LICSW, MSWAC is a supervisory trauma clinician and lead trainer at Community Connections a private, not-for-profit agency providing a full range of human services in metropolitan Washington, D.C. She was an original member of the Community Connections Trauma Work Group which developed the Trauma Recovery and Empowerment Model (TREM), has co-led numerous group treatment interventions in areas such as Trauma Recovery and Empowerment, Parenting Skills, and Domestic Violence, and has served as a clinical case manager and clinical housing coordinator before her more recent positions as a supervisory trauma clinician in two federally-funded research projects and as a lead trainer.

Q: Why did you enter the trauma treatment field?

A: I began working at Community Connections in 1991. One of the first individuals with whom I worked was a trauma survivor who had been the victim of incest by her father when she was five years old. She had been diagnosed with bipolar disorder and borderline personality disorder. Neither diagnosis adequately explained the symptoms and behaviors she experienced. The Tegretol she was prescribed did nothing to curb the emotional disregulation with which she struggled. She was often suicidal and sometimes self-injurious. Additionally, she would 'fire' me about every three months. A very astute supervisor helped me to view these firings not as a sign of her borderline personality disorder, but rather as her way to maintain a sense of power in our relationship. My supervisor also helped me to understand that she had never had someone she could trust in her life, and she was not sure if she could trust me either. In 1993, Maxine Harris, Ph.D. CEO of Community Connections and author of *Trauma Recovery and Empowerment Model*, *TREM* [1998] asked for staff members who were interested in forming a workgroup to write *TREM*. I jumped at the chance. Maybe this treatment would help this person and many like her. While we were writing *TREM*, I thought of her and other individuals with whom I was working. I wondered what topics would be helpful to them, what questions would assist them in understanding the links between their abuse and the symptoms and behaviors they had, and what skills would help them avoid revictimization.

When the TREM intervention was ready to be offered to the first group of female survivors, I asked this individual if she was interested. She was nervous, but quickly agreed. The group was a transformative experience for her. She learned so much about herself, her reasons for self-injuring, and made sense of the mental-health symptoms she had developed. Through her eyes, I saw the need for and value of trauma treatment. As a TREM trainer, I am fortunate to train other clinicians so that they can offer transformative treatment to survivors.

Q: Can you tell us what you consider to be the most helpful stabilization skill or tool one can teach to a trauma survivor?

A: The most helpful stabilization tool that any survivor can learn is the ability to self-soothe. Trauma survivors often experience flashbacks, troubling thoughts of the events, and triggers. In addition, they try to remain psychiatrically stable and stay sober. This is a tremendous amount for them to handle. When they were abused, they used strategies that helped them get relief quickly. These "feel good now, pay later" strategies, such as drugs, alcohol, food, sex, and gambling, had huge downsides. To be able to help survivors develop skills that they can use when feeling distress not only helps them to be the healthy, stable individual they desire to be, but it also helps them to avoid revictimization. Far too many survivors are re-abused while drunk or high or have sex in order to feel intimacy, but end up feeling used and abused all over again. Developing self-soothing skills can stop this cycle of revictimization and self-destructive behavior.

Q: Can you tell us one thing you think all trauma-focused clinicians should know?

A: Trauma-focused clinicians need to know that being trauma-focused makes a difference. Programs around the country have found that trauma-informed care increases retention rates. For example, Oklahoma has implemented trauma-informed care at two of its large mental-health centers, changing the way they schedule and conduct intake interviews and altering the questions to be more trauma-informed. Prior to these changes only 33% of the individuals who came for an intake interview came back for services. After making the trauma-informed changes, 66% engaged in services. Other programs have noticed differences in overall adherence to treatment and better outcomes on consumer and staff satisfaction surveys. Trauma-focused care helps us to be the clinicians our clients need us to be and the clinicians we always intended to be.

Submitted by Lori L. Beyer, MSW, LICSW, MSWAC

Attachment Theory, Mentalization-Based Treatments and the Intergenerational Transmission of Trauma

Attachment theory has helped clarify the distortions that occur and continue in intimate relationships when people are exposed to chronic childhood attachment trauma. ("Attachment trauma" is used here to describe a developmental environment characterized by ongoing neglect, overwhelming affects, in addition to physical, sexual, and emotional abuse.) Adults whose early attachments have been shaped in a chronically traumatizing environment often replicate problematic attachments with their own children. This process, called the "intergenerational transmission of trauma" was first observed during the 1970's, as children of Holocaust survivors were noted to exhibit post-traumatic symptoms that echoed those of their parents. More recently these observations have been applied to traumatized children whose parents experienced attachment trauma. Several attachment-based interventions for traumatized parents and children have been developed to prevent this intergenerational transmission of trauma.

Chronic attachment trauma may lead to a wide array of problems in self-regulation. Adults who experienced attachment trauma in childhood often have difficulty managing their emotions (either as excessive or lack of emotional expression), their relationships (they may be avoidant or enmeshed in their relationships), and their thinking (due to problems in managing attention or concentration, or vulnerability to dissociation or paranoia). Some adults with these histories find relief in substance use or self harm, even as these may create further problems in their lives. When emotionally distressed, adults with these vulnerabilities may find it difficult to keep their child's needs in mind as they become enveloped by their own preoccupations, fears, distortions, or misattributions (Beebe, 2005). From the attachment perspective, the parent at those times fails to keep their child's separate mind in mind. As a consequence, the parent may fail to protect the child from unbearable states of arousal due to the parent's preoccupations, distortions, misattributions. The child's separate mind is unrecognized, ignored, or experienced as a threat to the parent. (One frequently hears these types of misattributions, as when a mother accuses her 1-year-old of crying "just to get on my nerves," or another unhappy child is threatened that they will be given "something to cry about.") The parent who has grown up with an insecure attachment, may have limited capacity to tolerate challenges, frustrations, another person's unhappiness. Yet these are the demands of childrearing. Research suggests that these difficulties, referred to as "misattunement," usually reflect the parent's own unresolved losses or posttraumatic states, which are stimulated in the process of parenting (Beebe, 2005). Misattunement can characterize the parent/child relationship from birth, through the first year of life while attachment patterns are being established, and can be identified by 12 months of age. The intergenerational transmission of trauma begins during the first year of life. Thus intervention should occur as early as possible, to help the parent to develop a more secure attachment between the parent and child.

Specific interventions to address the intergenerational transmission of trauma are needed. Adults in psychotherapy to resolve their own trauma histories usually focus on their own attachment relationships. They may not be able to notice or cope with the ways they reenact their trauma with their children. It has been observed that treatment that addresses a parent's own trauma history does not necessarily prevent the intergenerational transmission of trauma. Since the intergenerational transmission of trauma begins in infancy, interventions with parents to prevent this transmission should start as soon as possible after the birth of their children.

In recent years several interventions have been developed that focus specifically on improving the attachment relationship between parents and children. The purpose of these interventions is to enhance the security of the child's attachment. Because the child's attachment pattern is an adaptation to the type of attachment environment that the parent creates, these interventions focus on enhancing the parent's capacity to provide a secure attachment. This process occurs by increasing the parent's ability to recognize and respond to their child's separate mind, and to become clearer about noticing their child's wishes, thoughts, feelings, and intentions as distinct from their own. Often, the parent becomes more aware of her/his own thoughts, feelings, and intentions in the process. This process of recognition is referred to as enhancing the parent's ability to "mentalize" (Bateman & Fonagy, 2007). Mentalization-based interventions occur in both group and individual formats, some of which occur in the clinic and others in the family's home.

Among these programs are Minding the Baby (Slade, Sadler et al, 2005) an in-home based intervention, based at the Yale Child Study Center; Parenting from the Inside Out (Suchman, da Coste et al, 2012) implemented at the Connecticut Mental Health Center, and the APT Foundation; the Child First Program (developed by Darcy Lowell, MD), initially based at Bridgeport Hospital and now being implemented at multiple sites in Connecticut and in other states), and Circle of Security (Marvin, Cooper et al, 2002), which was developed in Washington State and has been brought to Connecticut by Charlie Slaughter of CT DCF. Clinicians from the DMHAS Young Adult Program and Child First have been trained to implement Circle Of Security.

Submitted by Ellen Nasper, PhD

For a complete list of references for this article please visit: www.womensconsortium.org/references_Trauma_Matters.cfm.

Featured Resource

The Body Remembers Casebook: Unifying Methods and Models in the Treatment of Trauma and PTSD

By Babette Rothschild

I am pleased to share the newest addition to my professional bookshelf. Although published in 2003, *The Body Remembers Casebook* is not outdated. The author builds on (and reviews) the basic principles in the precursor to the workbook, *The Body Remembers*: *The Psychophysiology of Trauma and Trauma Treatment.* The *Casebook* is not a manualized treatment protocol, but rather demonstrates a variety of approaches to clinical work with trauma survivors. There are applications of cognitive behavioral therapy, somatic therapies, Neuro-Linguistic Programming (NLP), psychodynamic theory and Eye Movement Desensitization Reprocessing (EMDR), (and many others) to different clinical presentations. Rothschild spends some time discussing the use of common sense in the therapy session and stresses that without this common sense harm can be caused even when using an evidence-based approach. In addition to the theoretical applications, there are two chapters that are unusual and captivating. The first one is titled 'No Techniques Required' and a second titled 'Learning from Mistakes and Failure.' Both chapters illustrate the development of clinical common sense and the importance of following the direction of the person in front of you. *Casebook* is easy to read and makes clear the importance of expanding the clinical tool box in your work.

Submitted by Eileen M. Russo, MA, LADC

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